EFFECTIVE FOR SERVICES BEGINNING _____
MONTH DAY YEAR

175 XXXXXX1D00
MEDICAID IDENTIFICATION NUMBER

VALID FOR LISTED MONTH ONLY

ELIGIBILITY DETERMINATION FOR WOMEN'S HEALTH MEDICAID PROGRAM

PATIENT'S NAME: _____
PATIENT'S ADDRESS: _____
_____
CITY: _____ STATE: _____
ZIP CODE: _____ COUNTY: _____

TELEPHONE NUMBER: DAY: _____
EVENING: _____
SOCIAL SECURITY NO.: _____
PATIENT'S RECORD NO.: _____
DATE OF INTERVIEW: _____

DO YOU HAVE HEALTH INSURANCE THAT COVERS THE COST OF CANCER TREATMENT? ☐YES ☐NO

FORM 285 ATTACHED: ☐YES ☐NO

LINE NUMBER	APPLICANT'S NAME			DATE OF BIRTH			RACE (OPTIONAL)	SEX
	FIRST NAME	M.I.	LAST NAME	MO	DAY	YR		
01								

SWORN STATEMENT OF APPLICANT

I UNDERSTAND THAT THIS IS A TEMPORARY DETERMINATION OF MY ELIGIBILITY FOR MEDICAID AND THAT A RIGHT FROM THE START MEDICAID (RSM)/DEPARTMENT OF FAMILY AND CHILDREN SERVICES WORKER WILL DETERMINE MY CONTINUING ELIGIBILITY. I UNDERSTAND THAT I MUST GIVE TRUE AND CORRECT INFORMATION ABOUT MYSELF AND MY SITUATION. I UNDERSTAND THAT I MUST REPORT ANY CHANGES IN MY CIRCUMSTANCES WITHIN TEN (10) DAYS OF BECOMING AWARE OF THE CHANGE. I UNDERSTAND THAT WHEN THE FINAL ELIGIBILITY DETERMINATION IS COMPLETED, I HAVE THE RIGHT TO A FAIR HEARING IF I DO NOT LIKE THE DECISION ON MY CASE. I CAN REQUEST A FAIR HEARING BY CONTACTING THE RIGHT FROM THE START MEDICAID PROJECT AT 1-800-809-7276.

I CERTIFY THAT THE INFORMATION I HAVE PROVIDED IS CORRECT. I HAVE READ (OR HAD READ TO ME) AND UNDERSTAND THE INFORMATION ON THIS FORM.

_____ _____
DATE OF APPLICATION APPLICANT'S SIGNATURE

_____ _____ _____
DATE OF COMPLETION COMPLETED BY (PLEASE PRINT) TITLE

_____
SIGNATURE OF INDIVIDUAL COMPLETING FORM

PROVIDER CERTIFICATION:

I CERTIFY THAT THE WOMAN FOR WHOM THIS DETERMINATION IS MADE WAS SCREENED IN ACCORDANCE WITH THE REQUIREMENTS OF PUBLIC LAW 106-354. ON _____, HER DIAGNOSIS MET THE REQUIREMENTS FOR THE BCC MEDICAID COVERAGE IN GEORGIA. A COPY OF THIS APPLICATION HAS BEEN FORWARDED TO THE APPROPRIATE DFACS/RSM OFFICE FOR A DETERMINATION OF ONGOING ELIGIBILITY.

_____ _____
PROVIDER SIGNATURE TITLE

_____ _____
PROVIDER NAME PROVIDER NUMBER

_____
PROVIDER TELEPHONE NUMBER

DMA-632-W